TXCOMP

HIDE

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	HOUSTON WEST FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Lost Time
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	00
MTC Date	08/22/2011

Linkage Carrier Representative Details

Carrier Box Number	19
Carrier FEIN	741727735
Carrier Name	Flahive Ogden & Latson

Policy Details

Policy Effective Date	07/01/2011
Policy Expiration Date	07/01/2012
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	COMMERCE & INDUSTRY INSURANCE CO
Insurer FEIN	131938623
Insurer Email	
Insured Type	C
Business Name	
Address Line 1	PO BOX 133677
Address Line 2	
City	AUSTIN
State	Texas
ZIP/Postal Code	78711
County	Anderson
Country	United States
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	CENIKOR FOUNDATION INC
FEIN	760031861
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	4525 Glenwood Ave
Address Line 2	
City	Deer Park
State	Texas
ZIP/Postal Code	775367901
County	Harris
Country	United States
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	[redacted]
Email	
Insurer FEIN	131938623
Insurer Name	COMMERCE INDUSTRY US
TPA FEIN	132925174
TPA Name	AIG DOMESTIC CLAIMS INC.
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Male
Marital Status	Married
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	V
Phone Country Code	USA
Phone Area Code	[redacted]
Phone Number	[redacted]
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	[redacted]
Date Reported to Employer	[redacted]
Date of first work day missed	08/19/2011
Cause of Injury Category	
Cause of Injury	Falling or Flying Object
How the injury/occupational disease occurred.	WHILE STACKING WOOD ONE FELL OFF LINE HITTING EE
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	N
Provide the date you returned to work	
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	
Country	
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Toe(s)			Fracture - breaking of bone or cartilage

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	4525 Glenwood Ave
Address Line 2	
City/Town	Deer Park
State	Texas
ZIP/Postal Code	775367901
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	WAREHOUSE
Date of Hire	[redacted]
Was injured worker hired or	

recruited in Texas?	
On what date did injured worker start this position?	
Pay Period	Weekly
Gross Wages per Pay Period	35000
Hourly Rate	
Number of hours per week	
Days worked per week	5
Did injured worker routinely work overtime?	
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?	
Amount	
Frequency you were furnished this amount.	
Second Job	

Second Job Information

Non-Claim Employer

Employer's Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region

Non-Claim Employer Contact

First Name
Last Name
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?
Weekly amount of loss

Treating Doctor Information

First Name
Last Name
Name Suffix
Address Business Name
Address Line 1
Address Line 2
City/Town
State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

[redacted]

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code

Phone Area Code
Phone Number
Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top

TXCOMP

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	HOUSTON WEST FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Medical Only
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	04
MTC Date	05/22/2012

Linkage Carrier Representative Details

Carrier Box Number	19
Carrier FEIN	741727735
Carrier Name	Flahive Ogden & Latson

Policy Details

Policy Effective Date	07/01/2011
Policy Expiration Date	07/01/2012
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	COMMERCE & INDUSTRY INSURANCE CO
Insurer FEIN	131938623
Insurer Email	
Insured Type	C
Business Name	
Address Line 1	PO BOX 133677
Address Line 2	
City	AUSTIN
State	Texas
ZIP/Postal Code	78711
County	Anderson
Country	United States
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	
FEIN	
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	
Address Line 2	
City	
State	
ZIP/Postal Code	
County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	[redacted]
Email	
Insurer FEIN	131938623
Insurer Name	COMMERCE INDUSTRY US
TPA FEIN	132925174
TPA Name	AIG DOMESTIC CLAIMS INC.
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Female
Marital Status	Married
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	[redacted]
Date Reported to Employer	[redacted]
Date of first work day missed	
Cause of Injury Category	
Cause of Injury	Cumulative, Not Otherwise Classified - all other
How the injury/occupational disease occurred.	PSYCHOLOGICAL ABUSE
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	N
Provide the date you returned to work	
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	
Country	
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?	
On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?	

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Multiple Body Parts			All Other Cumulative Injuries, Not Otherwise Classified

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	11111 Katy Fwy Ste 500 FRWY
Address Line 2	
City/Town	Houston
State	Texas
ZIP/Postal Code	770792110
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	COUNSELOR
Date of Hire	[redacted]
Was injured worker hired or	

recruited in Texas?	
On what date did injured worker start this position?	
Pay Period	Weekly
Gross Wages per Pay Period	50000
Hourly Rate	
Number of hours per week	
Days worked per week	5
Did injured worker routinely work overtime?	
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?	
Amount	
Frequency you were furnished this amount.	
Second Job	

Second Job Information

Non-Claim Employer

Employer's Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region

Non-Claim Employer Contact

First Name
Last Name
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?
Weekly amount of loss

Treating Doctor Information

First Name
Last Name
Name Suffix
Address Business Name
Address Line 1
Address Line 2
City/Town
State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

[redacted]

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code

Phone Area Code
Phone Number
Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top

TXCOMP

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	HOUSTON EAST FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Lost Time
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	00
MTC Date	05/05/2011

Linkage Carrier Representative Details

Carrier Box Number	
Carrier FEIN	
Carrier Name	

Policy Details

Policy Effective Date	07/01/2010
Policy Expiration Date	07/01/2011
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	
Insurer FEIN	
Insurer Email	
Insured Type	
Business Name	
Address Line 1	
Address Line 2	
City	
State	
ZIP/Postal Code	
County	
Country	
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	
FEIN	
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	
Address Line 2	
City	
State	
ZIP/Postal Code	
County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	[redacted]
Email	
Insurer FEIN	131938623
Insurer Name	COMMERCE INDUSTRY US
TPA FEIN	132925174
TPA Name	AIG DOMESTIC CLAIMS INC.
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Male
Marital Status	Single
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	V
Phone Country Code	USA
Phone Area Code	[redacted]
Phone Number	[redacted]
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	[redacted]
Date Reported to Employer	[redacted]
Date of first work day missed	[redacted]
Cause of Injury Category	
Cause of Injury	On Same Level
How the injury/occupational disease occurred.	EE WAS WORKING WITH A MANDRIL FELL
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	N
Provide the date you returned to work	
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	
Country	
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?	
On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?	

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Low Back Area (Lumbar Area & Lumbo-Sacral)			Strain

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor Fndtn
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	4525 Glenwood Ave
Address Line 2	
City/Town	Deer Park
State	Texas
ZIP/Postal Code	775367901
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	LABORER
Date of Hire	[redacted]
Was injured worker hired or	

recruited in Texas?	
On what date did injured worker start this position?	
Pay Period	Weekly
Gross Wages per Pay Period	35000
Hourly Rate	
Number of hours per week	
Days worked per week	5
Did injured worker routinely work overtime?	
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?	
Amount	
Frequency you were furnished this amount.	
Second Job	

Second Job Information

Non-Claim Employer

Employer's Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region

Non-Claim Employer Contact

First Name
Last Name
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?
Weekly amount of loss

Treating Doctor Information

First Name
Last Name
Name Suffix
Address Business Name
Address Line 1
Address Line 2
City/Town
State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code

Phone Area Code
Phone Number
Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top

TXCOMP

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	HOUSTON EAST FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Lost Time
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	00
MTC Date	07/19/2011

Linkage Carrier Representative Details

Carrier Box Number	19
Carrier FEIN	741727735
Carrier Name	Flahive Ogden & Latson

Policy Details

Policy Effective Date	07/01/2010
Policy Expiration Date	07/01/2011
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	COMMERCE & INDUSTRY INSURANCE CO
Insurer FEIN	131938623
Insurer Email	
Insured Type	C
Business Name	
Address Line 1	PO BOX 133677
Address Line 2	
City	AUSTIN
State	Texas
ZIP/Postal Code	78711
County	Anderson
Country	United States
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	CENIKOR FOUNDATION INC
FEIN	760031861
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	4525 Glenwood Ave
Address Line 2	
City	Deer Park
State	Texas
ZIP/Postal Code	775367901
County	Harris
Country	United States
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	710776041
Email	
Insurer FEIN	131938623
Insurer Name	COMMERCE INDUSTRY US
TPA FEIN	132925174
TPA Name	AIG DOMESTIC CLAIMS INC.
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Male
Marital Status	Single
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension
Email Address

Claim Information

You are reporting an
Are you represented by an Attorney or Lay Representative?
If yes, date representation began?
Date of Injury [redacted]
Time of Injury [redacted]
Date Reported to Employer [redacted]
Date of first work day missed [redacted]
Cause of Injury Category
Cause of Injury Twisting
How the injury/occupational disease occurred. EE STEPPING OVER PALLET AND TWISTED ANKLE
Did injured worker see a doctor? No
Date of Death
Cause of Death
Have you returned to work? N
Provide the date you returned to work
If you have returned to work, what is your work status?
If you have returned to work, what is your wage status?
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
If accident occurred outside of Texas give County Name
If accident occurred outside of Texas, on what date did the injured worker leave Texas

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?	
On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?	

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Ankle - tarsals			Sprain

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor Fndtn
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	4525 Glenwood Ave
Address Line 2	
City/Town	Deer Park
State	Texas
ZIP/Postal Code	775367901
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	LABORER
Date of Hire	[redacted]
Was injured worker hired or recruited in Texas?	
On what date did injured worker	

start this position?	
Pay Period	Weekly
Gross Wages per Pay Period	35000
Hourly Rate	
Number of hours per week	
Days worked per week	5
Did injured worker routinely work overtime?	
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?	
Amount	
Frequency you were furnished this amount.	
Second Job	

Second Job Information

Non-Claim Employer

Employer's Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region

Non-Claim Employer Contact

First Name
Last Name
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?
Weekly amount of loss

Treating Doctor Information

First Name
Last Name
Name Suffix
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County

Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number

Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top

TXCOMP

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	FORT WORTH FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Medical Only
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	00
MTC Date	03/17/2016

Linkage Carrier Representative Details

Carrier Box Number	19
Carrier FEIN	741727735
Carrier Name	Flahive Ogden & Latson

Policy Details

Policy Effective Date	07/01/2015
Policy Expiration Date	07/01/2016
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	GRANITE STATE INSURANCE CO
Insurer FEIN	020140690
Insurer Email	
Insured Type	C
Business Name	
Address Line 1	PO Box 13367
Address Line 2	
City	Austin
State	Texas
ZIP/Postal Code	787113367
County	Travis
Country	United States
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	
FEIN	
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	
Address Line 2	
City	
State	
ZIP/Postal Code	
County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	710978841
Email	
Insurer FEIN	020140690
Insurer Name	GRANITE STATE INSURANCE CO.
TPA FEIN	132925174
TPA Name	AIG CLAIMS INC
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Male
Marital Status	Single
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	[redacted]
Number of Dependents	0
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	[redacted]
Date Reported to Employer	[redacted]
Date of first work day missed	
Cause of Injury Category	
Cause of Injury	Moving Parts of Machine
How the injury/occupational disease occurred.	WHILE FEEDING A COMPUND INTO A PRESS MACHINE IW THOUGHT THE MACHINE WAS FINISHED AND WAS NOT
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	N
Provide the date you returned to work	
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	Cenikor Fndtn
Address Line 1	2209 S Main St
Address Line 2	
City/Town	Fort Worth
State	Texas
ZIP/Postal Code	761102110
Texas County	
Country	United States
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Finger(s) - other than thumb			Amputation

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor Fndtn
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	2209 S Main St
Address Line 2	
City/Town	Fort Worth
State	Texas
ZIP/Postal Code	761102110
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	UNKNOWN
Date of Hire	[redacted]
Was injured worker hired or recruited in Texas?	
On what date did injured worker	

start this position?
Pay Period
Gross Wages per Pay Period
Hourly Rate
Number of hours per week
Days worked per week
Did injured worker routinely work overtime?
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?
Amount
Frequency you were furnished this amount.
Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region

Non-Claim Employer Contact

First Name
Last Name
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?
Weekly amount of loss

Treating Doctor Information

First Name
Last Name
Name Suffix
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County

Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number

Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top

TXCOMP

HIDE

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	HOUSTON WEST FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Medical Only
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	00
MTC Date	03/06/2017

Linkage Carrier Representative Details

Carrier Box Number	19
Carrier FEIN	741727735
Carrier Name	Flahive Ogden & Latson

Policy Details

Policy Effective Date	07/01/2016
Policy Expiration Date	07/01/2017
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	Aig Property Casualty Co
Insurer FEIN	251118791
Insurer Email	
Insured Type	C
Business Name	
Address Line 1	PO Box 13367
Address Line 2	
City	Austin
State	Texas
ZIP/Postal Code	787113367
County	Travis
Country	United States
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	CENIKOR FOUNDATION INC
FEIN	760031861
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	4525 Glenwood Ave
Address Line 2	
City	Deer Park
State	Texas
ZIP/Postal Code	775367901
County	Harris
Country	United States
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	[redacted]
Email	
Insurer FEIN	251118791
Insurer Name	CHARTIS PROPERTY CASUALTY CO
TPA FEIN	132925174
TPA Name	AIG CLAIMS INC.
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Female
Marital Status	Married
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	0
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	V
Phone Country Code	USA
Phone Area Code	[redacted]
Phone Number	[redacted]
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	[redacted]
Date Reported to Employer	[redacted]
Date of first work day missed	
Cause of Injury Category	
Cause of Injury	Fall, Slip, Trip, Not Otherwise Classified
How the injury/occupational disease occurred.	WALKING IN FROM THE PARKING LOT AND SHE FELL AT THE FRONT ENTRANCE.
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	N
Provide the date you returned to work	
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	
Country	
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Skull			Fracture - breaking of bone or cartilage

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor Foundation I
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	4525 Glenwood Ave
Address Line 2	
City/Town	Deer Park
State	Texas
ZIP/Postal Code	775365999
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	NURSE
Date of Hire	[redacted]
Was injured worker hired or	

recruited in Texas?
On what date did injured worker start this position?
Pay Period
Gross Wages per Pay Period
Hourly Rate
Number of hours per week
Days worked per week
Did injured worker routinely work overtime?
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?
Amount
Frequency you were furnished this amount.
Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region

Non-Claim Employer Contact

First Name
Last Name
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?
Weekly amount of loss

Treating Doctor Information

First Name
Last Name
Name Suffix
Address Business Name
Address Line 1
Address Line 2
City/Town
State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code

Phone Area Code
Phone Number
Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top

TXCOMP

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	FORT WORTH FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Lost Time
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	00
MTC Date	09/11/2012

Linkage Carrier Representative Details

Carrier Box Number	19
Carrier FEIN	741727735
Carrier Name	Flahive Ogden & Latson

Policy Details

Policy Effective Date	07/01/2012
Policy Expiration Date	07/01/2013
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	COMMERCE & INDUSTRY INSURANCE CO
Insurer FEIN	131938623
Insurer Email	
Insured Type	C
Business Name	
Address Line 1	PO BOX 133677
Address Line 2	
City	AUSTIN
State	Texas
ZIP/Postal Code	78711
County	Anderson
Country	United States
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	CENIKOR FOUNDATION INC
FEIN	760031861
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	2209 S Main St
Address Line 2	
City	Fort Worth
State	Texas
ZIP/Postal Code	761102110
County	Tarrant
Country	United States
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	[redacted]
Email	
Insurer FEIN	131938623
Insurer Name	COMMERCE INDUSTRY US
TPA FEIN	132925174
TPA Name	AIG DOMESTIC CLAIMS INC.
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Male
Marital Status	Single
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	V
Phone Country Code	USA
Phone Area Code	[redacted]
Phone Number	[redacted]
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	[redacted]
Date Reported to Employer	[redacted]
Date of first work day missed	[redacted]
Cause of Injury Category	
Cause of Injury	Machine or Machinery
How the injury/occupational disease occurred.	FINGERS PINCHED BWT STEEL DIE RESULTING IN BOTH HANDS GETTING CAUGHT IN THE BRAKE PRESS
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	N
Provide the date you returned to work	
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	
Country	
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?	
On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?	

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Multiple Upper Extremities			Crushing

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor Fndtn
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	2209 S Main St
Address Line 2	
City/Town	Fort Worth
State	Texas
ZIP/Postal Code	761102110
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	MANUFACTURING
Date of Hire	[redacted]
Was injured worker hired or recruited in Texas?	
On what date did injured worker	

start this position?	
Pay Period	Weekly
Gross Wages per Pay Period	50000
Hourly Rate	
Number of hours per week	
Days worked per week	5
Did injured worker routinely work overtime?	
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?	
Amount	
Frequency you were furnished this amount.	
Second Job	

Second Job Information

Non-Claim Employer

Employer's Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region

Non-Claim Employer Contact

First Name
Last Name
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?
Weekly amount of loss

Treating Doctor Information

First Name
Last Name
Name Suffix
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County

Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number

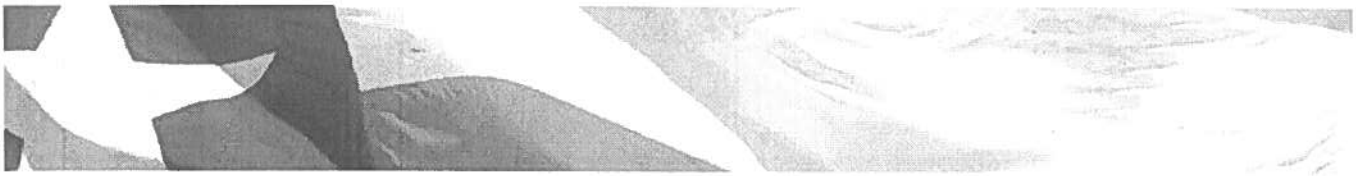
Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top



TXCOMP

HIDE

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	WACO FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Medical Only
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	00
MTC Date	08/01/2015

Linkage Carrier Representative Details

Carrier Box Number	19
Carrier FEIN	741727735
Carrier Name	Flahive Ogden & Latson

Policy Details

Policy Effective Date	07/01/2015
Policy Expiration Date	07/01/2016
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	GRANITE STATE INSURANCE CO
Insurer FEIN	020140690
Insurer Email	
Insured Type	C
Business Name	
Address Line 1	PO Box 13367
Address Line 2	
City	Austin
State	Texas
ZIP/Postal Code	787113367
County	Travis
Country	United States
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	Cenikor Fndtn
FEIN	760031861
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	11111 Katy Fwy Ste 500
Address Line 2	
City	Houston
State	Texas
ZIP/Postal Code	770792114
County	Harris
Country	United States
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	[redacted]
Email	
Insurer FEIN	020140690
Insurer Name	GRANITE STATE INSURANCE CO.
TPA FEIN	132925174
TPA Name	AIG CLAIMS INC
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Female
Marital Status	Married
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	0
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	V
Phone Country Code	USA
Phone Area Code	[redacted]
Phone Number	[redacted]
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	[redacted]
Date Reported to Employer	[redacted]
Date of first work day missed	
Cause of Injury Category	
Cause of Injury	Hand Tool, Utensil; Not Powered
How the injury/occupational disease occurred.	EE SHARPENING KNIFE CUT HAND
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	N
Provide the date you returned to work	
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	
Country	
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Hand - metacarpals and corresponding muscles			Laceration

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor Fndtn
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	11111 Katy Fwy
Address Line 2	
City/Town	Houston
State	Texas
ZIP/Postal Code	770792114
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	COOK
Date of Hire	[redacted]
Was injured worker hired or	

recruited in Texas?

On what date did injured worker start this position?

Pay Period

Gross Wages per Pay Period

Hourly Rate

Number of hours per week

Days worked per week

Did injured worker routinely work overtime?

Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?

Amount

Frequency you were furnished this amount.

Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Non-Claim Employer Contact

First Name

Last Name

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?

Weekly amount of loss

Treating Doctor Information

First Name

Last Name

Name Suffix

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code

Phone Area Code
Phone Number
Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top

TXCOMP

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	DALLAS FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Lost Time
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	00
MTC Date	08/08/2012

Linkage Carrier Representative Details

Carrier Box Number	19
Carrier FEIN	741727735
Carrier Name	Flahive Ogden & Latson

Policy Details

Policy Effective Date	07/01/2011
Policy Expiration Date	07/01/2012
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	COMMERCE & INDUSTRY INSURANCE CO
Insurer FEIN	131938623
Insurer Email	
Insured Type	C
Business Name	
Address Line 1	PO BOX 133677
Address Line 2	
City	AUSTIN
State	Texas
ZIP/Postal Code	78711
County	Anderson
Country	United States
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	Cenikor Foundation Inc
FEIN	760031861
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	11111 Katy Fwy Ste 500 Ste 535
Address Line 2	
City	Houston
State	Texas
ZIP/Postal Code	770792110
County	Harris
Country	United States
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	[redacted]
Email	
Insurer FEIN	131938623
Insurer Name	COMMERCE INDUSTRY US
TPA FEIN	132925174
TPA Name	AIG DOMESTIC CLAIMS INC.
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Male
Marital Status	Single
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	V
Phone Country Code	USA
Phone Area Code	[redacted]
Phone Number	[redacted]
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	[redacted]
Date Reported to Employer	[redacted]
Date of first work day missed	[redacted]
Cause of Injury Category	
Cause of Injury	Lifting
How the injury/occupational disease occurred.	EE WAS LIFTING A HANGER PLATE
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	N
Provide the date you returned to work	
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	
Country	
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Low Back Area (Lumbar Area & Lumbo-Sacral)			Strain

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Gst
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	4201 JANADA
Address Line 2	
City/Town	HALLOM CITY
State	Texas
ZIP/Postal Code	76107
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	WELDER
Date of Hire	[redacted]
Was injured worker hired or	

recruited in Texas?	
On what date did injured worker start this position?	
Pay Period	Weekly
Gross Wages per Pay Period	50000
Hourly Rate	
Number of hours per week	
Days worked per week	5
Did injured worker routinely work overtime?	
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?	
Amount	
Frequency you were furnished this amount.	
Second Job	

Second Job Information

Non-Claim Employer

Employer's Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region

Non-Claim Employer Contact

First Name
Last Name
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?
Weekly amount of loss

Treating Doctor Information

First Name
Last Name
Name Suffix
Address Business Name
Address Line 1
Address Line 2
City/Town
State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code

Phone Area Code
Phone Number
Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top

TXCOMP

HIDE

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	FORT WORTH FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Medical Only
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	00
MTC Date	08/03/2016

Linkage Carrier Representative Details

Carrier Box Number	19
Carrier FEIN	741727735
Carrier Name	Flahive Ogden & Latson

Policy Details

Policy Effective Date	07/01/2016
Policy Expiration Date	07/01/2017
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	Aig Property Casualty Co
Insurer FEIN	251118791
Insurer Email	
Insured Type	C
Business Name	
Address Line 1	PO Box 13367
Address Line 2	
City	Austin
State	Texas
ZIP/Postal Code	787113367
County	Travis
Country	United States
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	Cenikor Fndtn
FEIN	760031861
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	11111 Katy Fwy Ste 500
Address Line 2	
City	Houston
State	Texas
ZIP/Postal Code	770792114
County	Harris
Country	United States
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	[redacted]
Email	
Insurer FEIN	251118791
Insurer Name	CHARTIS PROPERTY CASUALTY CO
TPA FEIN	132925174
TPA Name	AIG CLAIMS INC.
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Female
Marital Status	Married
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	0
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	V
Phone Country Code	USA
Phone Area Code	[redacted]
Phone Number	[redacted]
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	[redacted]
Date Reported to Employer	[redacted]
Date of first work day missed	
Cause of Injury Category	
Cause of Injury	From Different Level (Elevation) - off wall, catwalk, bridge, etc.
How the injury/occupational disease occurred.	SHE STATED THAT SHE HAD TRIPPED AND FALLEN DOWN SOME STAIRS. TURNING HER ANKLE AND SCRAPING HER ARM.
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	N
Provide the date you returned to work	
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	
Country	
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Multiple Body Parts			All Other Specific Injuries, Not Otherwise Classified

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor Foundation I
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	11111 Katy Fwy Ste 500
Address Line 2	
City/Town	Houston
State	Texas
ZIP/Postal Code	770792144
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	ADMIN ASSISTANT
Date of Hire	[redacted]
Was injured worker hired or	

recruited in Texas?
On what date did injured worker start this position?
Pay Period
Gross Wages per Pay Period
Hourly Rate
Number of hours per week
Days worked per week
Did injured worker routinely work overtime?
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?
Amount
Frequency you were furnished this amount.
Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region

Non-Claim Employer Contact

First Name
Last Name
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?
Weekly amount of loss

Treating Doctor Information

First Name
Last Name
Name Suffix
Address Business Name
Address Line 1
Address Line 2
City/Town
State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code

Phone Area Code
Phone Number
Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top

TXCOMP

HIDE

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	WACO FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Lost Time
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	04
MTC Date	10/24/2013

Linkage Carrier Representative Details

Carrier Box Number	19
Carrier FEIN	741727735
Carrier Name	Flahive Ogden & Latson

Policy Details

Policy Effective Date	07/01/2013
Policy Expiration Date	07/01/2014
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	GRANITE STATE INSURANCE CO
Insurer FEIN	020140690
Insurer Email	
Insured Type	C
Business Name	
Address Line 1	PO Box 13367
Address Line 2	
City	Austin
State	Texas
ZIP/Postal Code	787113367
County	Travis
Country	United States
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	
FEIN	
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	
Address Line 2	
City	
State	
ZIP/Postal Code	
County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	[redacted]
Email	
Insurer FEIN	020140690
Insurer Name	GRANITE STATE INSURANCE CO.
TPA FEIN	132925174
TPA Name	AIG DOMESTIC CLAIMS INC.
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Female
Marital Status	Married
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	0
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	[redacted]
Date Reported to Employer	[redacted]
Date of first work day missed	[redacted]
Cause of Injury Category	
Cause of Injury	Strain or Injury By, Not Otherwise Classified
How the injury/occupational disease occurred.	EE FOUND FACE UP ON THE FLOOR IN BREAKROOM NONRESPONSIVE
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	Y
Provide the date you returned to work	10/14/2013
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	
Country	
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Soft Tissue - other than larynx or trachea			Strain

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor Foundation Inc
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	3015 Herring Ave
Address Line 2	
City/Town	Waco
State	Texas
ZIP/Postal Code	767083238
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	BEHAVIORAL HEALTH TECH
Date of Hire	[redacted]
Was injured worker hired or	

recruited in Texas?	
On what date did injured worker start this position?	
Pay Period	
Gross Wages per Pay Period	
Hourly Rate	
Number of hours per week	
Days worked per week	5
Did injured worker routinely work overtime?	
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?	
Amount	
Frequency you were furnished this amount.	
Second Job	

Second Job Information

Non-Claim Employer

Employer's Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	
Country	
State/Province/Region	

Non-Claim Employer Contact

First Name	
Last Name	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Non-Claim Wage

Is there a loss of wages from the second job?	
Weekly amount of loss	

Treating Doctor Information

First Name	
Last Name	
Name Suffix	
Address Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code

Phone Area Code
Phone Number
Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top

TXCOMP

HIDE

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	HOUSTON WEST FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Medical Only
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	00
MTC Date	03/31/2017

Linkage Carrier Representative Details

Carrier Box Number	19
Carrier FEIN	741727735
Carrier Name	Flahive Ogden & Latson

Policy Details

Policy Effective Date	07/01/2016
Policy Expiration Date	07/01/2017
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	Aig Property Casualty Co
Insurer FEIN	251118791
Insurer Email	
Insured Type	C
Business Name	
Address Line 1	PO Box 13367
Address Line 2	
City	Austin
State	Texas
ZIP/Postal Code	787113367
County	Travis
Country	United States
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	CENIKOR FOUNDATION INC
FEIN	760031861
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	4525 Glenwood Ave
Address Line 2	
City	Deer Park
State	Texas
ZIP/Postal Code	775367901
County	Harris
Country	United States
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	[redacted]
Email	
Insurer FEIN	251118791
Insurer Name	AIG CASUALTY
TPA FEIN	132925174
TPA Name	AIG DOMESTIC CLAIMS INC.
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Male
Marital Status	Not Reported
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	0
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	V
Phone Country Code	USA
Phone Area Code	[redacted]
Phone Number	[redacted]
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	
Date Reported to Employer	[redacted]
Date of first work day missed	
Cause of Injury Category	
Cause of Injury	Object Handled by Others
How the injury/occupational disease occurred.	ANOTHER INDIVIDUAL THREW A BOX IN THE BACK OF A TRUCK AND STRUCK THE INJURED INDIVIDUALS LEG.
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	N
Provide the date you returned to work	
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	
Country	
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Knee - patella			Contusion-bruise-intact skin surface, hematoma

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor Foundation I
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	4525 Glenwood Ave
Address Line 2	
City/Town	Deer Park
State	Texas
ZIP/Postal Code	775365999
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	LABORER
Date of Hire	[redacted]
Was injured worker hired or	

recruited in Texas?	
On what date did injured worker start this position?	
Pay Period	Weekly
Gross Wages per Pay Period	26110
Hourly Rate	
Number of hours per week	
Days worked per week	5
Did injured worker routinely work overtime?	
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?	
Amount	
Frequency you were furnished this amount.	
Second Job	

Second Job Information

Non-Claim Employer

Employer's Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region

Non-Claim Employer Contact

First Name
Last Name
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?
Weekly amount of loss

Treating Doctor Information

First Name
Last Name
Name Suffix
Address Business Name
Address Line 1
Address Line 2
City/Town
State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code

Phone Area Code
Phone Number
Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top

TXCOMP

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	HOUSTON WEST FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Medical Only
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	00
MTC Date	03/07/2013

Linkage Carrier Representative Details

Carrier Box Number	19
Carrier FEIN	741727735
Carrier Name	Flahive Ogden & Latson

Policy Details

Policy Effective Date	07/01/2012
Policy Expiration Date	07/01/2013
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	COMMERCE & INDUSTRY INSURANCE CO
Insurer FEIN	131938623
Insurer Email	
Insured Type	C
Business Name	
Address Line 1	PO BOX 133677
Address Line 2	
City	AUSTIN
State	Texas
ZIP/Postal Code	78711
County	Anderson
Country	United States
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	CENIKOR FOUNDATION INC
FEIN	760031861
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	4525 Glenwood Ave
Address Line 2	
City	Deer Park
State	Texas
ZIP/Postal Code	775367901
County	Harris
Country	United States
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	[redacted]
Email	
Insurer FEIN	131938623
Insurer Name	COMMERCE INDUSTRY US
TPA FEIN	132925174
TPA Name	AIG DOMESTIC CLAIMS INC.
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Male
Marital Status	Single
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	V
Phone Country Code	USA
Phone Area Code	[redacted]
Phone Number	[redacted]
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	[redacted]
Date Reported to Employer	[redacted]
Date of first work day missed	
Cause of Injury Category	
Cause of Injury	Cut, Puncture, Scrape, Not Otherwise Classified
How the injury/occupational disease occurred.	EMPLOYEE WAS HOOKING UP TRAILER AND SMASHED HAND WITH FORKLIFT
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	N
Provide the date you returned to work	
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	Cenikor Foundation Inc
Address Line 1	4525 Glenwood Ave
Address Line 2	
City/Town	Deer Park
State	Texas
ZIP/Postal Code	775365999
Texas County	
Country	United States
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Hand - metacarpals and corresponding muscles			Laceration

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor Foundation Inc
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	4525 Glenwood Ave
Address Line 2	
City/Town	Deer Park
State	Texas
ZIP/Postal Code	775365999
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	LABORER
Date of Hire	[redacted]
Was injured worker hired or	

recruited in Texas?	
On what date did injured worker start this position?	
Pay Period	Weekly
Gross Wages per Pay Period	50000
Hourly Rate	
Number of hours per week	
Days worked per week	5
Did injured worker routinely work overtime?	
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?	
Amount	
Frequency you were furnished this amount.	
Second Job	

Second Job Information

Non-Claim Employer

Employer's Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	
Country	
State/Province/Region	

Non-Claim Employer Contact

First Name	
Last Name	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Non-Claim Wage

Is there a loss of wages from the second job?	
Weekly amount of loss	

Treating Doctor Information

First Name	
Last Name	
Name Suffix	
Address Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code

Phone Area Code
Phone Number
Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top

TXCOMP

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	HOUSTON EAST FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Lost Time
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	00
MTC Date	11/24/2010

Linkage Carrier Representative Details

Carrier Box Number
Carrier FEIN
Carrier Name

Policy Details

Policy Effective Date	07/01/2010
Policy Expiration Date	07/01/2011
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name
Insurer FEIN
Insurer Email
Insured Type
Business Name
Address Line 1
Address Line 2
City
State
ZIP/Postal Code
County
Country
State/Province/Region

Linkage Employer Details

Linkage Employer Name
FEIN
Email
Insured Location Number
Insured Name
Insured Reported Number
Self Insured Indicator
Sic Code
Business Name
Address Line 1
Address Line 2
City
State
ZIP/Postal Code
County
Country
State/Province/Region
Phone Type
Phone Country Code

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	[redacted]
Email	
Insurer FEIN	131938623
Insurer Name	COMMERCE INDUSTRY US
TPA FEIN	132925174
TPA Name	AIG DOMESTIC CLAIMS INC.
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Female
Marital Status	Married
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	V
Phone Country Code	USA
Phone Area Code	[redacted]
Phone Number	[redacted]
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	[redacted]
Date Reported to Employer	[redacted]
Date of first work day missed	[redacted]
Cause of Injury Category	
Cause of Injury	Into Openings - shafts, excavations, floor openings, etc.
How the injury/occupational disease occurred.	EMP FELL IN HALLWAY
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	N
Provide the date you returned to work	
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	Cenikor Foundation Inc
Address Line 1	7676 Hillmont St Ste 190
Address Line 2	
City/Town	Houston
State	Texas
ZIP/Postal Code	770406467
Texas County	
Country	United States
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?	
On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?	

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Multiple Body Parts			Strain

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor Foundation Inc
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	7676 Hillmont St Ste 190
Address Line 2	
City/Town	Houston
State	Texas
ZIP/Postal Code	770406467
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	COUNSELOR
Date of Hire	[redacted]
Was injured worker hired or recruited in Texas?	
On what date did injured worker	

start this position?	
Pay Period	Weekly
Gross Wages per Pay Period	45560
Hourly Rate	
Number of hours per week	
Days worked per week	5
Did injured worker routinely work overtime?	
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?	
Amount	
Frequency you were furnished this amount.	
Second Job	

Second Job Information

Non-Claim Employer

Employer's Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region

Non-Claim Employer Contact

First Name
Last Name
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?
Weekly amount of loss

Treating Doctor Information

First Name
Last Name
Name Suffix
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County

Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number

Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top

TXCOMP

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	HOUSTON WEST FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Medical Only
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	00
MTC Date	04/02/2012

Linkage Carrier Representative Details

Carrier Box Number	19
Carrier FEIN	741727735
Carrier Name	Flahive Ogden & Latson

Policy Details

Policy Effective Date	07/01/2011
Policy Expiration Date	07/01/2012
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	COMMERCE & INDUSTRY INSURANCE CO
Insurer FEIN	131938623
Insurer Email	
Insured Type	C
Business Name	
Address Line 1	PO BOX 133677
Address Line 2	
City	AUSTIN
State	Texas
ZIP/Postal Code	78711
County	Anderson
Country	United States
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	Cenikor Foundation Inc
FEIN	760031861
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	7676 Hillmont St Ste 190
Address Line 2	
City	Houston
State	Texas
ZIP/Postal Code	770406467
County	Harris
Country	United States
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	[redacted]
Email	
Insurer FEIN	131938623
Insurer Name	COMMERCE INDUSTRY US
TPA FEIN	132925174
TPA Name	AIG DOMESTIC CLAIMS INC.
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Female
Marital Status	Married
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	[redacted]
Date Reported to Employer	[redacted]
Date of first work day missed	
Cause of Injury Category	
Cause of Injury	On Same Level
How the injury/occupational disease occurred.	SLIPPED AT DOOR AND STRUCK DOOR FRAME
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	N
Provide the date you returned to work	
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	Cenikor Fndtn
Address Line 1	11111 Katy Fwy
Address Line 2	
City/Town	Houston
State	Texas
ZIP/Postal Code	770792114
Texas County	
Country	United States
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?	
On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?	

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Shoulder(s) - Armpit, Rotator Cuff, Trapezius, Clavicle, Scapula			Contusion-bruise-intact skin surface, hematoma

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor Fndtn
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	11111 Katy Fwy
Address Line 2	
City/Town	Houston
State	Texas
ZIP/Postal Code	770792114
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	COUNSELOR
Date of Hire	[redacted]
Was injured worker hired or	

recruited in Texas?	
On what date did injured worker start this position?	
Pay Period	Weekly
Gross Wages per Pay Period	45560
Hourly Rate	
Number of hours per week	
Days worked per week	5
Did injured worker routinely work overtime?	
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?	
Amount	
Frequency you were furnished this amount.	
Second Job	

Second Job Information

Non-Claim Employer

Employer's Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region

Non-Claim Employer Contact

First Name
Last Name
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?
Weekly amount of loss

Treating Doctor Information

First Name
Last Name
Name Suffix
Address Business Name
Address Line 1
Address Line 2
City/Town
State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code

Phone Area Code
Phone Number
Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top

TXCOMP

HIDE

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	HOUSTON EAST FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Lost Time
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	00
MTC Date	11/14/2012

Linkage Carrier Representative Details

Carrier Box Number	19
Carrier FEIN	741727735
Carrier Name	Flahive Ogden & Latson

Policy Details

Policy Effective Date	07/01/2012
Policy Expiration Date	07/01/2013
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	COMMERCE & INDUSTRY INSURANCE CO
Insurer FEIN	131938623
Insurer Email	
Insured Type	C
Business Name	
Address Line 1	PO BOX 133677
Address Line 2	
City	AUSTIN
State	Texas
ZIP/Postal Code	78711
County	Anderson
Country	United States
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	
FEIN	
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	
Address Line 2	
City	
State	
ZIP/Postal Code	
County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	[redacted]
Email	
Insurer FEIN	131938623
Insurer Name	COMMERCE INDUSTRY US
TPA FEIN	132925174
TPA Name	AIG DOMESTIC CLAIMS INC.
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Female
Marital Status	Single
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	V
Phone Country Code	USA
Phone Area Code	[redacted]
Phone Number	[redacted]
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	[redacted]
Date Reported to Employer	[redacted]
Date of first work day missed	[redacted]
Cause of Injury Category	
Cause of Injury	Fall, Slip, Trip, Not Otherwise Classified
How the injury/occupational disease occurred.	IW TRIPPED FELL OVER LUGGAGE PLACED IN HALLWAY
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	N
Provide the date you returned to work	
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	
Country	
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Knee - patella			Contusion-bruise-intact skin surface, hematoma

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor Foundation Inc
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	4525 Glenwood Ave
Address Line 2	
City/Town	Deer Park
State	Texas
ZIP/Postal Code	775365999
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	FACILITY NURSE
Date of Hire	
Was injured worker hired or	

recruited in Texas?	
On what date did injured worker start this position?	
Pay Period	Weekly
Gross Wages per Pay Period	50000
Hourly Rate	
Number of hours per week	
Days worked per week	5
Did injured worker routinely work overtime?	
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?	
Amount	
Frequency you were furnished this amount.	
Second Job	

Second Job Information

Non-Claim Employer

Employer's Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region

Non-Claim Employer Contact

First Name
Last Name
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?
Weekly amount of loss

Treating Doctor Information

First Name
Last Name
Name Suffix
Address Business Name
Address Line 1
Address Line 2
City/Town
State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code

Phone Area Code
Phone Number
Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top

TXCOMP

HIDE

Back

Claim Details

General Claim Details

Claim Number	[redacted]
Field Office	HOUSTON WEST FIELD OFFICE
Role Selected	IE
Representative SubType Selected	
Role Specific	
Filed By	
Filing Status	
Date Created	[redacted]
Created By	EDI_148
Claim Received Date	[redacted]
Claim Established By	Employer's First Report Injury/Fatality
Carrier Claim Number	[redacted]

Claim Status Details

Claim Type	Lost Time
Claim Status	
Agreement to Compensate	
Late Reason Code	
Date of Representation	
Representative Type	

Number Var Segment Details

Number of Benefit Adjustments	
Number of Death Dependent Payee	
Number of Payment Adjustments	
Number of Perm Impairments	
Number of Ptd Red Earnings Recoveries	

Jurisdiction Details

Agency Claim Number	
Jurisdiction	Texas

Transaction Details

MTC	00
MTC Date	05/09/2014

Linkage Carrier Representative Details

Carrier Box Number	19
Carrier FEIN	741727735
Carrier Name	Flahive Ogden & Latson

Policy Details

Policy Effective Date	07/01/2013
Policy Expiration Date	07/01/2014
Policy Number	[redacted]

Linkage Insurer Details

Insurer Name	GRANITE STATE INSURANCE CO
Insurer FEIN	020140690
Insurer Email	
Insured Type	C
Business Name	
Address Line 1	PO Box 13367
Address Line 2	
City	Austin
State	Texas
ZIP/Postal Code	787113367
County	Travis
Country	United States
State/Province/Region	

Linkage Employer Details

Linkage Employer Name	
FEIN	
Email	
Insured Location Number	
Insured Name	
Insured Reported Number	
Self Insured Indicator	
Sic Code	
Business Name	
Address Line 1	
Address Line 2	
City	
State	
ZIP/Postal Code	
County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	

Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Claim Admin Details

Claim Admin Claim Number	[redacted]
Email	
Insurer FEIN	020140690
Insurer Name	GRANITE STATE INSURANCE CO.
TPA FEIN	132925174
TPA Name	AIG DOMESTIC CLAIMS INC.
Claim Admin Business Name	
Address Line 1	1999 BRYANT ST. 24TH FLOOR
Address Line 2	
City	DALLAS
State	Texas
ZIP/Postal Code	75201
Texas County	
Country	
State/Province/Region	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Injured Worker Personal Information

First Name	[redacted]
Middle Name	
Last Name	[redacted]
Name Suffix	
Social Security Number	[redacted]
Driver License/ID Number	
Jurisdiction	
Green Card Number	
Foreign ID	
Country	
Date of Birth	[redacted]
Gender	Male
Marital Status	Single
Was injured worker married at the time of death?	
Did injured worker have any prior marriages?	No
Number of Dependents	0
Race/Ethnicity	Other
Primary Non-English Language	
Address Line 1	[redacted]
Address Line 2	
City/Town	[redacted]
State	[redacted]
ZIP/Postal Code	[redacted]
Texas County	
Country	United States

State/Province/Region	
Phone Type	V
Phone Country Code	USA
Phone Area Code	[redacted]
Phone Number	[redacted]
Phone Extension	
Email Address	

Claim Information

You are reporting an	
Are you represented by an Attorney or Lay Representative?	
If yes, date representation began?	
Date of Injury	[redacted]
Time of Injury	[redacted]
Date Reported to Employer	[redacted]
Date of first work day missed	[redacted]
Cause of Injury Category	
Cause of Injury	Object Being Lifted or Handled
How the injury/occupational disease occurred.	EE MOVING MATERIAL W DOLLY AND STRUCK IN HEAD BY DOLLY
Did injured worker see a doctor?	No
Date of Death	
Cause of Death	
Have you returned to work?	N
Provide the date you returned to work	
If you have returned to work, what is your work status?	
If you have returned to work, what is your wage status?	
Address Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	
Country	
State/Province/Region	
If accident occurred outside of Texas give County Name	
If accident occurred outside of Texas, on what date did the injured worker leave Texas	

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?	
On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?	

Injury Details

One item found.

Injured Body Category	Injured Body Part	Side Injured	Finger or Toe Injured	Nature of Injury
	Multiple Head Injury			Laceration

Witnesses

First Name	Last Name	Name Suffix
No information found		

Claim Employer Information

Employer's (Company's) Name	Cenikor Fndtn
Supervisor's First Name	
Supervisor's Last Name	
Address Line 1	4525 Glenwood Ave
Address Line 2	
City/Town	Deer Park
State	Texas
ZIP/Postal Code	775365999
Texas County	
Country	United States
State/Province/Region	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	
Fax Country Code	
Fax Area Code	
Fax Number	

Occupation and Wage Information

Occupation at time of injury	LABORER
Date of Hire	[redacted]
Was injured worker hired or recruited in Texas?	
On what date did injured worker	

start this position?	
Pay Period	
Gross Wages per Pay Period	
Hourly Rate	
Number of hours per week	
Days worked per week	5
Did injured worker routinely work overtime?	
Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?	
Amount	
Frequency you were furnished this amount.	
Second Job	

Second Job Information

Non-Claim Employer

Employer's Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	
Country	
State/Province/Region	

Non-Claim Employer Contact

First Name	
Last Name	
Phone Type	
Phone Country Code	
Phone Area Code	
Phone Number	
Phone Extension	

Non-Claim Wage

Is there a loss of wages from the second job?	
Weekly amount of loss	

Treating Doctor Information

First Name	
Last Name	
Name Suffix	
Address Business Name	
Address Line 1	
Address Line 2	
City/Town	
State	
ZIP/Postal Code	
Texas County	

Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name	Last Name	Name Suffix	Date of Divorce	Date of Death	Address
No information found					

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2
City/Town
State
ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number

Phone Extension
License Number
Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker
Name of Person Acting on Behalf of Beneficiary

Back

Back to Top